Reset Form

Name of Provider
Provider NPI #
Provider Medicaid Legacy (Optional) #

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION INCONTINENCE SUPPLIES

Instructions: The Certificate of Medical Necessity (CMN) must be used for incontinence garments and disposable supplies under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests which require prior authorization will be considered.

Name of Consumer	Consumer Medicaid Number

Street Address	City/State/Zip	Date of Birth

Section A

Diagnosis(es): Include ICD-9 codes (mandatory) and description *(optional)*

Supply Requested

Type of incontinence garment/disposable supply needed	# Needed per month X 12 months

Section B - Prescriber Attestation and Signature/Date

Prescriber Name *(printed)*	Date of Last Face to Face Examination of Consumer

I certify that I am the prescriber identified above. I certify that the information in Section A of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature *(No stamps)*	Date	Prescriber NPI #